a) Comprehensiveness

(1) What problem does this proposal address?

Our current health care system is fraught with inefficiency, inequality, and unfettered cost-shifting. Within the state of Colorado, we have regions where individuals have access to the best that money can buy, while other regions have uninsured rates that exceed 30 percent. The total number of uninsured within our state is approaching 800,000 and more and more are falling into those ranks each day as health insurance becomes more unaffordable to both employers and employees alike. Moreover, having insurance in our present system does not always mean we are truly insured against catastrophe. Of Americans forced into medically related bankruptcy, nearly 75 percent had health insurance at the start of their illness.

Providers are being squeezed from every direction. Reimbursements are not keeping pace with health care inflation, and ever-increasing administrative and non-patient care responsibilities are consuming provider staff resources and time. Providers are being faced with varying and sometimes conflicting standards of care depending on a patient's coverage. Many areas across the state face poor access to health care not just because of poor coverage but also due to a shortage of providers.

Business is losing its ability to successfully compete in a global market. Corporations are being faced with undesirable choices – sometimes having to choose between remaining competitive in the marketplace or keeping health care benefits for their workforce.

Everyone involved with the financing of health care is frustrated, as many feel that the quality of care does not equate with the money spent and there seems to be no effective means of cost containment.

Consumers, providers, business and those who finance health care are all concerned that our money could be spent more effectively and that medicine could be delivered in a safer and more uniform fashion, but the fragmentation of our current system makes change virtually impossible without major reformation on all fronts. In fact, with all the discussion over "Universal Health Care," the reality is that we don't just need universal access, we need universal reform.

** See Attachment A: "Illness and Injury As Contributors to Bankruptcy," Health Affairs, Feb. 2005; and Attachment B: "Accounting for the Cost of Health Care in the United States," McKinsey Global Institute, January 2007*

a)(2) What are the objectives of your proposal?

Our objective is to rein in the disparities of financing, delivery, access and consumption, and to provide quality, equitable health care in a cost-efficient manner. This proposal does not only lay out a path to universal coverage but actually creates a universal health care system that is publicly funded, with private coverage available as a choice above a standard benefits package. It is regulated by a governing board that is accountable to the people and operates much like a public utility. The main objectives are to standardize delivery of care and equalize, as much as possible, access to care across the state while minimizing administrative costs.

** See Attachment C: Eight Principles of Health Care Reform, adapted from "Building a Better Health Care System," published by the National Coalition on Health Care, 2004*

b) General

(1) Please describe your proposal in detail.

The Health Care for All Colorado plan is a proposal that calls for the creation of the Colorado Health Services program (CHS). The CHS is a single, comprehensive, publicly financed program designed for the integration of the financing, delivery, and administration of health care. The CHS is funded publicly and the monies designated are separate and insulated from the legislature and the general budget of the state. Administration of the CHS is governed by a board representative of the entire state and accountable to the people. Although the financing of health care is public, the delivery of care remains primarily in the private sector, allowing participants to continue operating on a fee-for-service model, if they choose.

Every resident has equal access to the benefits outlined within the program, with access to the providers and hospitals of their choice. Each individual will have a "medical home" with choice of personal primary-care provider or community clinic.

The plan covers all primary and preventive care, specialty care, surgical care, hospitalization, laboratory and x-ray services, emergency care, automobile and work-related injuries, prescription drugs, durable medical equipment, pathology and autopsies, mental health services, substance abuse treatment, patient education, chiropractic services, dental services, basic vision care, audiology services and treatment, medical transport, physical therapy and rehabilitation and home health and hospice services. Full long-term care will be incorporated over time, with consideration for the increased demand that will occur upon its initial inclusion. In the first year there will be allowance for a 25% increase in home and community-based care (in addition to any savings from institutional care and anticipated savings from consolidation of all current programs for LTC, including 80 federal programs). Long-term care will be financed by CHS, with the exception of 'room and board' payments by patients who are not low-income requiring institutional care.

The program calls for a statewide, fully integrated Information Technology network that can be expanded upon with COHRIO Colorado Health Regional Information Organization. With expanded CORHIO we will be able to track outcomes, utilization, and expenditures, which are vital in deciding the allocation of resources and improving the delivery of care across the state. Since the profit motive is removed from the financing mechanism, the CHS is free to fulfill the mission statement of a true egalitarian health care system, where all residents of Colorado can enjoy equal access to quality health care, and health care providers can concentrate on what they do best — taking care of patients, and where business can concentrate on what it does best — remaining competitive in a global market and driving economic growth. In a sense, the CHS is a publicly owned, not-for-profit insurance company, administered and governed as a public utility. Its operations will be mandated by law to be fiscally responsible, transparent and accountable to the people.

** See Attachment D: Draft Bill for Single Payer and Background*

b)(2) Who will benefit from this proposal? Who will be negatively affected by this proposal?

Every resident of the State of Colorado will benefit, as all will be fully covered with equal access under the benefits design laid out by the plan. They will have free choice of all eligible health care providers and hospitals across the state. No one will be subject to bankruptcy due to medical bills, and no one will be denied coverage due to a pre-existing condition.

All providers and hospitals will benefit as they no longer will have to design programs or build infrastructure to avoid seeing non-paying or poor paying patients. All providers and hospitals will be paid the same for the same level of service, thus eliminating the drive for profit in determining the quality of care. In fact, everyone will benefit because providers will start competing in areas where competition in medicine was meant to be — quality, safety, and outcomes. Because the burden of administration and bureaucracy is greatly reduced by dealing with only one system, the monetary savings can be re-invested into health initiatives, and providers can be freed up to do what they were trained to do — practice medicine. Because the playing field will be leveled, rural communities will benefit as physicians in underserved areas will be able to maintain competitive salaries with their urban colleagues.

Health care provider education will benefit, as this plan will use a portion of its budget to subsidize education of all state-recognized and licensed health care professions, as well as providing student loan payback programs for those who practice in high need areas.

Business will benefit markedly, as all employers will utilize the same comprehensive health insurance plan. They will have a healthier workforce and be able to compete for it. Expanded preventive care programs in the workplace will insure that employees find more job satisfaction and are healthier, all at no additional cost to employers. Businesses will have the opportunity to compete against one another on the merits of their production, thus leveling the playing field, as health care funding will be even across the board. The medical expense portion (which is the lion's share) of liability, workers compensation, and fleet insurance will be rolled into the program, eliminating the need to adjudicate health care costs or to prove whether or not an injury was job related. Employers will be free to hire quality employees with previous

injuries or pre-existing medical conditions without fear of driving up their insurance premiums.

Because health contributions for state and local government workers and retirees under the plan will be less than state and local governments now pay for worker and retiree health benefits, the net cost of the program to the state and local governments will result in significant savings. The public education system will also benefit from the ability to redirect funding to education.

A portion of those currently employed in the health insurance industry will be needed in other sectors. Many in that industry will be utilized in this program, as there will still be need for experienced administrators. For the others, it is the intent of this proposal to provide funding for re-education and job placement.

b)(3) How will your proposal impact specific groups of people (e.g. low income, rural, immigrant, ethnic minority, disabled)?

This proposal creates a single, statewide risk pool in which every resident is covered. Since clinics and hospitals are typically located in areas that attract patients with higher reimbursing coverage and many minority groups are clustered into specific geographic regions that represent a lower return on medical dollars invested; this program will level the playing field, as providers will receive the same reimbursement for the same level of care provided no matter what patient population they serve. The positive influence on these groups cannot be overstated. In fact, under this program it will be easier to create incentives to providers and hospitals to invest in underserved areas. Creating equal access to health care is also a major step forward in the war against poverty.

As a practical matter, it is much easier to coordinate public health initiatives when barriers to access (which are typically a problem in high need groups) are removed.

b)(4) Please provide any evidence regarding the success or failure of your approach. Please attach.

Most industrialized nations have demonstrated that they can provide universal access to health care for half the cost per capita that the United States currently spends. Because the United States is the last industrialized nation in the world to adopt a universal health care system, we have the unique opportunity to learn from the successes as well as the challenges of those nations and design a superior plan that is truly American.

** See Attachment E: "Health Spending in the United States and the Rest of the Industrialized World," Health Affairs, July/August 2005; Attachment F: "How Much Would a Single-Payer System Cost?" summaries of 19 federal and state studies since 1991, Physicians for a National Health Program; and National Coalition for Health Care Study, 2005: and Attachment G: NCHC Study on Four Models of Health Care Reform*

b)(5)How will the program(s) included in the proposal be governed and administered?

The governance and administration of this program is structured around the concept of the Federal Reserve. This proposal creates the Colorado Health Services program (CHS). The CHS is administrated by a governing board comprised of 15 members. The state will have five regional districts under the governing board for the purpose of local administration, billing processing, medical directorship, and oversight of programs that may be specific to regional needs. Three members from each of the five districts shall be appointed by the governor in a four year rotating cycle, so that one member from each district is appointed every four years. Thus, each member shall serve for a total of not less than 12 years. Those appointed by the governor must be approved by the senate and by a majority of the house members from each respective district.

The governor shall appoint an executive director of the CHS who shall act as program administrator. That position shall come under review every four years.

The CHS Board shall be the body that provides oversight and administrative direction for the CHS. All decisions of the CHS Board will be final in regard to administration and implementation of health care within the state unless otherwise directed by the courts or state

statute.

Since the delivery of health care is multi-faceted and the intent is to streamline administration and prevent duplication of state services, all state agencies that are related to health care will fall within the purview of the CHS Board. The department of Health Care Policy and Finance will be folded into the CHS since Medicaid will be eliminated.

To streamline and simplify licensing and credentialing of providers, hospitals, laboratories, etc., those offices under the Division of Regulatory Agencies (DORA) that regulate and license health-related providers will come under the administration of the CHS. This will greatly reduce redundant state bureaucracy, as well as reducing the administrative burden (and cost) to hospitals and providers for complying with state regulations.

Because this program is intended to promote the overall health of all Colorado, the Dept of Health shall work cooperatively with the CHS to implement various programs. Public health issues such as clean and safe water, air, and food supplies are vital to cost containment of the entire system. In the event of a natural disaster, such as an influenza epidemic, quick response and mass vaccination implementation is much easier within a comprehensive and integrated health system. This capability will result in the savings of many lives and resources. Public health education will also be an integral part of the CHS program, encompassing wellness, sex education in public schools, child rearing, anger management, etc., all of which have been shown to have positive outcomes toward saving resources. Because this program is unified, with centralized data-compiling capability, tracking the effects of such programs will be simplified, and adjustments made much easier in order to achieve desired goals and savings of valuable resources. Further, tracking chronic disease management will also be simplified, enabling the CHS to develop "best practices" programs that can then be implemented statewide.

The CHS board will convene quarterly. The Board must establish a process of open forum to the public. Their role is to discuss, debate, or refer to committee all issues related to the business and administration of the CHS. Once a year they will convene specifically for the purpose of meeting with providers to discuss and set provider fee schedules for the following year.

The CHS Board will also be responsible for creating statewide standards of care. With a standardized information technology program, reporting of outcomes, morbidity, mortality, resource utilization, etc., can then be utilized to improve on quality of care and to reward hospitals and providers with positive reinforcement for excellence. Because the CHS will be a not-for-profit entity, motivation is not to protect shareholder value, but to enhance the overall health of all Colorado residents.

Since malpractice is also a contributor to health care inflation, it, too, needs to be contained. The program calls for a Disciplinary and Litigation (D&L) Board under the auspices of the CHS, as well as a statewide CHS professional liability insurance pool for all participating providers. Since providers are part of the system, they will be covered by CHS professional liability insurance.

The D&L Board will be responsible for review of all claims to determine whether care provided deviated from accepted standards of care as laid out by the CHS. The main purpose of the D&L is to gather data on adverse outcomes, and to allow the malpractice accusation process to be educational instead of punitive. However, in order for this process to be successful, the findings and opinions of the D&L must be admissible as evidence in a court of law! This point cannot be overstated.

The CHS Board must create a yearly report and budget. The process of setting budgets, changes in benefits, etc., must be transparent and accountable to all the people.

This proposal calls for the establishment of the Colorado Health Services Trust (CHST), which is administered by the Colorado Health Services Board. The funds of the trust are to be used for the general operating budget of the CHS, reimbursement for care rendered, support of professional education, and for the health and general well-being of the people of Colorado. The trust will be separate and insulated from the general budget of the state Legislature in order to prevent health care dollars from being used as a political football as Medicare and Medicaid are currently.

In order for this system to remain viable, four key issues must be mandated by law:

1. The Legislature cannot remove funds allocated to the trust without the consent of the

people.

2. The CHS cannot operate in a deficit.
3. The overhead of the CHS cannot exceed 5% of total expenditures.
4. The CHS must have constitutional powers to contain costs.

These four necessary elements provide the foundation for sustainability. This literally forces society to make the hard choices and establish priorities; and it does so on a platform of public debate and through a democratic process — something that no other model can achieve.

In a sense, the CHS is a publicly owned, not-for-profit health insurance company run in a similar fashion to a public utility. Its operations must be fiscally responsible, transparent, and accountable to the people.

Although the mechanism of financing is publicly administered, the delivery of care is kept in the private sector. Hospitals and provider groups may practice on a fee-for-service, for-profit or not-for-profit status, but since reimbursement is equal across the board, innovation and competition will occur in medicine where it belongs — in quality, service, outcomes, and patient satisfaction.

One side issue to administration that will affect any program eventually chosen is the scenario of adverse selection, or the potential of a large influx of very sick people moving across state lines. (Countering this, of course, is the equally real potential of companies moving to Colorado because of the improved access to health care and favorable business climate). Many western states are currently looking at their own brand of "Universal Health Care." Colorado should begin to work with other western states to address this vital issue opening for debate the possibility of a Mountain States Health Alliance (MSHA). Because many western states are so sparsely populated they do not have the financial leverage necessary to contain cost or absorb excessive adverse selection. By forming a health alliance, western states can begin to pool resources for such things as bulk pharmaceutical purchasing, health care provider education, and portability of coverage that can be equitably honored across state lines. This is especially important to states such as Wyoming or Montana that lack the resources needed to establish high tech centers of excellence, such as transplant centers. Colorado could help to fill that void.

Finally, regarding the administration of this plan, it is hoped that in the near future we will actually see a federal plan come to fruition. This plan is intended to have the flexibility to be incorporated into a national health program, but provide equitable, affordable access to care here in Colorado until that day arrives.

** See Attachment H: Medicaid Transformation Matrix — A Model for Health Care Reform*

b)(6) To the best of your knowledge, will any federal or state laws or regulations need to be changed to implement this proposal (e.g. federal Medicaid waiver, Workers' Compensation, auto insurance, ERISA)? If known, what changes will be necessary?

Currently, Congress has recognized the need for major reform, but most recognize the lack of political will in our current leadership to move in that direction. However, Congress has appeared ready to help states with their individual plans. Since this proposal calls for a single risk pool, all federal and state monies currently earmarked for health care financing will be transferred to the CHS trust and fall under the budgetary purview of the CHS.

Medicaid and SCHIP waivers will be the easiest to achieve since the CHS program will be expanding access, eligibility, and benefits. Medicare will be slightly more complicated but doable. Currently, Medicare recipients are allowed to purchase "Medicare-Choice" type of private plans in which private plans "manage" their care for a small fee paid for by the federal government and the private plans are then reimbursed any payouts directly from the Center for Medicare and Medicaid Services (CMS). There is no reason that arrangement cannot be extended to this type of a program as long as it complies with federal CMS regulations for coverage.

The biggest potential stumbling block will be the federal Employee Retirement Income Security Act (ERISA). The 1974 Act was meant to protect employee retirement funds from unscrupulous employer groups. Although the emphasis was on retirement, some of the wording also dealt with health insurance coverage and protection of a "benefits" package. There have been a few major court decisions over the years in the application of ERISA preemption to health care. The most notable was the "Travelers Insurance" Supreme Court decision of 1995 and most recently *RILA vs. Fielder* federal district court case in July 2006 which struck down the

Maryland "fair share act" or what we have come to recognize as the WAL-MART act.

It is beyond the scope of this proposal to prepare an in-depth brief on ERISA interpretation. However, the "Travelers" court did lay out some specific guidelines. A state law will be preempted if:

1. It passes legislation that refers to ERISA specifically or requires reference to an ERISA plan in order to comply with state law; or

2. If there is a connection to an ERISA plan that could substantially affect a plan's benefits, administration, or structure, especially as it relates to multi-state corporations that have interstate-related benefits packages.

Nevertheless, it was not the intention of Congress to preempt laws of traditional state authority.

No matter what type of Colorado plan we eventually adopt, we will run into the potential of an ERISA-related suit; which is why a federal solution is ideal, but as of yet, we do not have that luxury. So, for now, we must look to the RILA case for guidance because there is some hope in presiding Judge Motz's opinion: "In light of what is generally perceived as a national health care crisis, it would seem that to the extent ERISA allows, it is strongly in the public interest to permit states to perform their traditional role of serving as laboratories for experiment in controlling costs and increasing the quality of health care for all citizens" — especially if cost as well as access were spread proportionately across all business sectors and individuals.

It is conceivable that any "Universal Health Care Plan" (no matter how it is financed) could be subject to a preemptive challenge on the grounds that an employer may terminate or modify an ERISA plan to make contributions to a public program, or a multi-state corporation would not be able to provide uniformity of cost or administration of a plan between firms in different states.

Congress could have never imagined in 1974 the current dilemma that states are facing in trying to provide and finance health care for their citizens. Having a state publicly financed system would never have entered their minds when Congress entertained ERISA legislation and, therefore, interpretation of ERISA preemption under a new set of social problems that go much

deeper than a few corporations' benefits packages is impossible to foresee; no matter what plan we adopt. There is no precedence!

We cannot, therefore, be timid in adopting a plan that is deemed proper for our state. If a plan is implemented and undergoes a challenge of ERISA preemption and the courts rule in favor of the plan, we go about our business. If the court strikes down the plan, then, in essence, no state plan will survive, or if they do, they will be greatly hampered in their attempts to provide state structured financing. If that occurs, it will then become painfully obvious that the only solution will be a federal solution and that will ultimately force the hand of Congress to act. We should not therefore get hung up on theoretical ERISA implications (no matter what plan we adopt) but move forward for what is felt to be best for all Coloradans and trust to Providence that we shall ultimately find a solution to our present condition no matter how the courts ultimately interpret ERISA.

There are also state laws such as TABOR that have the potential for hampering reform. However, when Representative Andrew Romanoff addressed the 208 Commission, he instructed them to find a visionary, workable system and the State Legislature would deal with financing and tax issues.

** See Attachment I: "ERISA Implications for State Health Care Access Initiatives: Impact of the Maryland 'Fair Share Act' Court Decision"*

b)(7) How will your program be implemented? How will your proposal transition from the current system to the proposal program? Over what time period?

This program will most likely operate using the insurance model. Once federal waivers for funding are obtained the transition will be seamless. Although it will take from several months up to one year to implement the sign up period, for businesses and individuals it will be no more difficult than changing insurance companies.

The state will have five administrative regions:

1. North-central and Northwest
2. South-central and Southwest

3. Southeast and East-central
4. Northeast
5. Denver metro

Each of the five administrative regions has insurance companies with trained staff and infrastructure in place. Their expertise will be needed for the transition and many of their skilled workers will be retained. For others, funding will need to be provided for job retraining and reemployment. The state has the option to contract out administrative services or to purchase the infrastructure from the existing insurance companies.

c) Access

(1)Does this proposal expand access?

Yes, this proposal creates a single risk pool in which every Colorado resident is included. As a result of this program, the uninsured rate in Colorado will approach zero. In fact, even migrant workers can be covered, as they will be paying into the system as will all other workers.

c)(2) How will this program affect safety net providers?

The traditional role of community health centers, such as the Valley-Wide Health Services of Southern Colorado, is to provide care to the indigent and poorly insured. Since funding for health care coverage will no longer be an issue, the focus of these organizations may change, but they still have an important role to play. Many times, access can also be limited by other factors, such as those encountered in geographically isolated small communities, among non-English speaking groups, or migrant workers. Community health centers already have the infrastructure to address those special needs so greater emphasis can be placed on minimizing the cultural, social, and geographical barriers that may hinder access.

d) Coverage

(1) Does your proposal "expand health care coverage?" How?

Yes, it creates a single risk pool and everyone residing in the state is covered. All residents are eligible for the same comprehensive benefits package which includes access to all

primary and preventive care, specialty care, surgical care, hospitalization, laboratory and x-ray services, emergency care, automobile and work-related injuries, prescription drugs, durable medical equipment, pathology and autopsies, mental health services, substance abuse treatment, patient education, chiropractic services, dental services, basic vision care, audiology services and treatment, medical transport, physical therapy and rehabilitation and home health and hospice care.

Full long-term care will be incorporated over time, with consideration of the increased demand that will occur upon its initial inclusion. In the first year there will be allowance for a 25% increase in home and community-based care (in addition to any savings from institutional care and anticipated savings from consolidation of all current programs for LTC, including 80 federal programs). Long-term care will be financed by CHS, with the exception of 'room and board' payments by patients who are not low-income needing institutional care.

** See Attachment J: Outline of PNHP proposal for expanding long-term care based on "A National Long-term Care Program for the United States: A Caring Vision," Dr. Christine Cassell, JAMA 12-4-91.*

d)(2) How will outreach and enrollment be conducted?

The five regional offices will be responsible for holding informational and sign up meetings through local community centers, clinics and hospitals. Outreach will occur through local media channels spearheaded by each of the five regional offices. Physician offices and hospitals can also be authorized to sign up their own patients. ID cards using magnetic stripes conforming to WEDI standards and with unique identification numbers not based on Social Security numbers will be issued upon registration. This process emphasizes the necessity for a single, standardized, statewide Patient Health Information Network (PHIN).

Having a sustainable and workable PHIN is vital to the success of this program, as we shall discuss later, and enrollment is just one of those reasons.

For the first two years of the program, everyone enrolled must be treated with

presumption of eligibility and the program, not the providers, should carry that risk.

d)(3) If applicable, how does your proposal define "resident?"

Anyone who has resided for three months or works in the state of Colorado or otherwise defined by the state legislature.

e) Affordability

(1) If applicable, what will enrollee and/or employer premium-sharing requirements be?

This program establishes a publicly owned state wide insurance company. There will be a mandate that every one in the state participate. Premiums will be collected either through payroll deductions or on the state quarterly estimated income tax filing. Employers have the option to pay all, part or none of the employee's contribution.

e)(2) How will co-payments and other cost-sharing be structured?

The RAND experiment of the 1970s and subsequent studies demonstrated that co-pays and deductibles do modify individual health behavior and utilization. However, there is no hard data to show that co-pays and deductibles actually save money within the system as a whole. In fact, we know that approximately 80 percent of health care spending is consumed by only 20 percent of the population in the form of chronic, long term, and catastrophic care in which co-pays and deductibles have no influence.

Co-pays and deductibles are just another mechanism for cost-shifting to the individual and, unfortunately, have their largest impact on the most vulnerable of the population. It also is a cost-shifting mechanism to the provider as it creates an additional layer of administration with a subsequent increase in the cost of doing business.

Patients must have some degree of personal responsibility for their own care. However, we are woefully lacking in sufficient data to suggest the most effective way to make people personally responsible for their health. Therefore, no co-pays or deductibles should be incurred for the first three to five years of this program until sufficient data on utilization can be

scrutinized and the public have input on it through the process outlined by the CHS.

f) Portability

(1) Please describe any provisions for assuring that individuals maintain access to coverage even as life circumstances (e.g. employment, public program eligibility) and health status change.

Because everyone is covered continuously, portability within the state is not an issue. Eligibility is not determined by pre-existing conditions and is not changed in the event of a catastrophic illness, injury, job change or unemployment. The system will cover emergency services provided out-of-state. Those that leave the state will be allowed COBRA coverage for a monthly premium for the term mandated by federal law with payments for care provided equal to the reimbursement paid to providers within the Colorado system for that set amount of time.

g) Benefits

(1) Please describe how and why you believe the benefits under your proposal are adequate, have appropriate limitations and address distinct populations.

The plan covers all primary and preventive care; specialty care; surgical care, hospitalization; laboratory and x-ray services; emergency care; vehicular-, sports-, and work-related injuries; prescription drugs; durable medical equipment; pathology and autopsies; mental health services; substance abuse treatment; patient education; chiropractic services; dental services; basic vision care; audiology services and treatment; medical transport; physical therapy and rehabilitation; and home health and hospice services, to be expanded to full long-term care.

This comprehensive range of services actually encompasses a broader range of coverage than one can presently receive under a single plan in the private insurance market.

Distinct population issues are addressed in that the covered services are equivalent across the state and regional offices will have the authority to deal with specific regional needs.

The benefits package will need to have some limitations, but deciding those limitations is an ever-changing and dynamic process. The CHS Board will have oversight of administration

and delivery of comprehensive health care services in all regions of the state.

g)(2) Please identify an existing Colorado Benefit package that is similar to the one(s) you are proposing (e.g. Small Group Standard Plan, Medicaid, etc) and describe any differences between the existing benefit package and your benefit package.

At present, there is no single existing benefits package for comparison. This is a combination of a comprehensive group health insurance plan and the bodily injury and medical coverage portion of Workers' Compensation and auto insurance.

However, we do have two examples that are close:

(a) Medicare, a publicly financed universal health care system, has operated successfully since 1965.

(b) The University of Denver Student Health Service, a single-payer universal health care program, has operated successfully since 1947.

A distinct advantage for employer groups under this plan is that the overhead imposed by managing and contracting with multiple types of health-related coverage will be eliminated. The fear of driving up the cost of Workers' Comp claims due to an accident or illness will be eliminated. Liability insurance for any organization will be limited to property damage, death, disability, and economic losses.

** See Attachment K: Medicare at 40*

h) Quality

(1) How will quality be defined, measured, and improved?

The current definitions of quality have been well outlined in papers presented by numerous prestigious organizations. A few are attached for your review. It is the intent of this program for the CHS Board to review the literature and to define quality as it applies to the specific needs of Colorado.

The great advantage of this program is that we have a single governing body accountable

to the people, providing the platform for public and professional input. Since the definition of quality is dynamic and may change as society and the practice of medicine changes, the CHS program outlines the process for defining the ever-changing definition of quality and how it is measured. The program utilizes various means of oversight, administration, and billing, as well as programs specific to regional needs. Further ensuring quality, the CHS maintains public channels of input and uses an electronic data system to permit transparency and determination of best practices and outcomes. Statewide coordination and administration of public health and infrastructure prevents duplication of state services. This process is more important than any static definition that may not meet the needs of Colorado in 20, 10, or even five years.

** See Attachment L: The 10 key quality principles that guide single payer, reprinted from "A Better Quality Alternative: Single Payer National Health System Reform," Schiff et al, JAMA 9/14/94; Attachment M: Colorado Quality Coalition, compiled by Colorado Clinical Collaborative, Colorado Patient Safety Coalition, COPIC, and CFMC.*

h)(2) How, if at all, will quality of care be improved (e.g. using methods such as applying evidence to medicine, using information technology, improving provider training, aligning provider payment with outcomes, and improving cultural competency including ethnicity, sexual orientation, gender identity, education and rural areas, etc.?)

The proposal calls for a confidential and secure statewide, integrated Patient Health Information Network (PHIN) system. (The foundation for such a program is already in place through the Colorado Regional Health Information Organization (CORHIO). Having single integrated tracking and reporting capabilities along with a single integrated program to interpret those results, the CHS has the unique opportunity to apply that data to the improvement of the system as a whole, something which is impossible under our current fragmented system.

A single, integrated system (Medicare being a current model) permits robust data collection that enables analyses of variations in spending and outcomes as well as over or under-utilization of services on a micro and macro level. This data can then be used to identify outliers or reward desired practice behaviors, from individual providers all the way to regional

administration.

With simultaneous tracking of expenditures, utilization, and outcomes, we will be better able to implement policies that strengthen and improve the quality and safety of care while ensuring sensitivity to cultural, linguistic, and geographic needs. This will permit the CHS to direct resources and provide incentives for desired outcomes including education needs for future providers.

i) Efficiency

(1) Does your proposal decrease or contain costs? How?

This program provides savings through several avenues:

1. By moving to a single integrated system of financing, the complex, confusing, and many times irrational layers of administration and bureaucracy will be dramatically reduced on both the provider and governing side. It is estimated that this action alone will save 15-20 percent of our current expenditures.

2. With the use of integrated PHIN (as outlined above), it is possible to track evidence-based outcomes and continually adjust the system for improvement of quality and safety as well as desired cost/benefit ratios.

3. As new technology and treatment modalities are introduced, they must come under the scrutiny of the CHS Board to determine future cost savings or health benefits. Patients and providers are free to pursue new treatment modalities that are not yet covered, but do so at their own expense.

4. With all patients having access to primary/preventive services and wellness education, many diseases (including teenage drug use and pregnancy) can be prevented, or their effects diminished with early intervention; with great savings over time.

5. Data reveals that a large percentage of the population in our jails and prisons are there due to substance abuse or mental health related crimes. With access to proper outpatient mental health services, we can drastically reduce prison expenditures at city, county, and state levels

while making room in our facilities for felons who are truly a menace to society.

6. By maintaining continuous access to care, malpractice awards will no longer have to consider continued treatment, creating savings for malpractice premiums.

7. The CHS will be authorized to maintain a single, statewide pharmacy formulary. Bulk purchasing will drive down pharmaceutical expenditures as well as durable medical goods, and encourage the use of generic medications when appropriate. Provider overhead will be reduced by having only one formulary to deal with. Because all pharmacies across the state will have access to the CHS drug pool, and because pharmaceuticals are a covered benefit, pharmacies will be reimbursed a dispensing fee, thus allowing small private pharmacies to compete and to remain in business, especially in rural communities where they are desperately needed.

8. Since providers and hospitals will be paid the same across the state for the same services, and with barriers to access for patients removed, the perpetual game of cost-shifting will end.

9. Considering that nursing home patient expenditures average $70,000 per year, the emphasis of this program will be on wellness and dignity, with the intent to expand home services for the disabled and elderly in order to minimize institutional care and realize savings in nursing home expenditures.

10. When patients have access to timely and appropriate care, the incidence of serious and costly complications due to delayed care can be dramatically reduced.

The above list is extensive but certainly not exhaustive. The true savings (because of the accumulative effects of the efficiencies in this program) will be enjoyed and shared by all and not just one segment of the system.

** See Attachment N: "Administrative Waste, a State-by-State Analysis of Single Payer, Physicians Group study; and Attachment O: Benchmarks*

i)(2) To what extent does your proposal use incentives for providers, consumers, plans or others to reward behavior that minimizes costs and maximizes access and quality in the health care services? Please explain.

Once a few years' worth of data have been gathered, it will be very easy to initiate a pay-for-performance package for providers. It is the intent of this program to do so.

Providing incentives for consumers is more difficult. Health habits, diet, child rearing techniques, etc., are very "value laden" and culturally diverse. Molding healthy behavior should be done in a progressive, not a regressive or punitive, fashion. For example, society does not have the fortitude to say "Gee, I'm sorry Mr. Smith, you have lung cancer and because you smoked for 40 years, we are not going to treat you." Instead, we estimate that the health care costs of a smoker are $30,000 more over their lifetime than of a non-smoker, and we add that much in taxes to the price of a pack of cigarettes over the average smoker's lifetime. We then take a portion of that to use for anti-smoking ads, smoking cessation programs, and most importantly, education beginning in primary school.

Because this is a publicly-financed program, the most effective ways to modify health behavior consist of applying "sin taxes" that go into the budget of the CHS, and to provide contribution incentives for individuals or groups who engage in wellness programs designated by the CHS.

i)(3) Does this proposal address transparency of costs and quality?

Yes, through the open forum process of the CHS Board. Data collection, outcomes, and expenditures etc. are all open to public review.

i)(4) How would your proposal impact administrative costs?

Through the streamlined process of a single integrated system of financing, the complex, confusing, costly, and many times irrational layers of administration and bureaucracy will be dramatically reduced on both the provider and governing side. By also removing the profit motive from the financing of health care, administrative costs can be reduced by as much as 15-

20 percent.

A distinct advantage for employer groups is that under this plan the overhead imposed by managing and contracting with multiple types of health-related coverage will be dramatically curtailed, possibly reduced to one payroll contribution or annual tax payment. The fear of driving up the cost of Workers' Comp claims due to an accident or illness will be eliminated. Liability insurance for any organization will be limited to property damage, death, and disability.

** See Attachment P: Report of Medical Loss Ratios, Health Affairs, 2006; and Attachment Q: Graphic slide of Medicare vs. Private Insurance Overhead*

j) Consumer choice and empowerment

(1) Does your proposal address consumer choice? If so, how?

Consumers will have their choice of any licensed health care provider and hospital across the state. This program also allows for consumer purchase of private insurance for any benefits not covered under the CHS. Consumers and providers may engage in services not covered by the CHS, e.g. cosmetic surgery, but those consumers are responsible for payment and providers are responsible for collections. Consumers will be empowered in their choices through access to quality information provided within an integrated health care system that provides greater transparency and access to data.

This proposal changes health care delivery from a market-driven model of consumers/providers to a model of individual choice of personal primary-care providers and collaborative decision-making.

j)(2) How, if at all, would your proposal help consumers to be more informed about and better equipped to engage in health care decisions?

Wellness and education are a main emphasis of this program, and part of its budget will be dedicated to public classes, education in the schools, and online education access. The CHS is designed to promote transparency in the data it gathers, allowing patients access to specific data that will help them in their choice of high quality providers and hospitals.

k) Wellness and prevention

(1) How does your proposal address wellness and prevention?

The single most effective way to promote wellness and prevention is by eliminating barriers to access. When preventive services are considered a standard of care and not a luxury, we have the opportunity to improve morbidity and mortality rates, as well as achieve earlier intervention in chronic diseases when treatment options are less costly. By including public health in the program we also have the opportunity to streamline a network of accessible statewide wellness projects.

l) Sustainability

(1) How is your proposal sustainable over the long term?

In addition to numerous cost-saving and oversight mechanisms, what makes this program sustainable is that it must, by legislative mandate, operate within its budget. The CHS needs to have the flexibility to grow with normal inflation, but if the public wishes to reduce the budget by reducing health care contributions and taxes, then they also must be involved in deciding what services are reduced or eliminated. If the public demands more services, then they must be willing to increase their health care contributions and taxes to do so. This program literally forces society to decide what it wants and needs, and what it can and cannot afford! In a sense, this is truly consumer-directed health care.

We assume that the amounts of state and county funding will be indexed by the allowable rate of growth in spending, i.e., GDP growth. Because health spending has grown considerably faster than rate of growth in state GDP, this will result in lower levels of health spending for state and county governments in future years. However, we assume that the amount of federal funding provided to the state in future years will be indexed to the average rate of growth in costs in these programs nationally - designed to assure that federal funding for the state is not reduced over time (thus, the program is budget neutral from the federal perspective.

We assume that the program is required to constrain the rate of growth in health spending so it does not exceed the long-term rate of growth in GDP for Colorado.

l)(2) How much do you estimate this proposal will cost? How much do you estimate this proposal will save? Please explain.

Regarding the funding of the CHS, Speaker of the House Andrew Romanoff was very clear that he wants us to build a sustainable program and let the legislature determine the funding specifics. We would however, expect a total budget of approximately $16 billion in 2004 dollars, representing conservatively, a savings of 20 percent in 2004 dollars, or approximately $4 billion.

l)(3) Who will pay for any new costs under your proposal?

In 2004 (the last year that we have good data), approximate total health care expenditures for the State of Colorado were just over $20 billion. Approximately 60 percent or about $12-$13 billion of that came from private insurance and out-of-pocket consumer spending. (A portion of those private insurance premiums was paid for with tax dollars for government employees). The remainder was funded through federal and state programs (Medicare and Medicaid, etc.). Assume a conservative total savings to the system of 20 percent as outlined previously. We would expect a total budget of approximately $16 billion in 2004 dollars.

Approximately $7 billion of spending in 2004 came through government funding (in the form of Medicare, Medicaid, etc). All current government health care dollars (federal, state, county and city) will be transferred into the CHS Trust Fund and continue to be a source of funding. This will require the CHS to come up with $9 billion in additional funding.

Two mechanisms of funding have been proposed; the first is based on an income tax model.

In 2004, individual income tax returns were a little over $100 billion with wages and salaries being approximately $74 billion of that amount. By setting individual income tax at 6 percent with a 4 percent employer payroll tax, the system could be fully funded. Although this incurs a perceived tax increase, for a family of four at 300 percent of the federal poverty level (approx. $58,000 per year), their total tax payment will still be less than half of the current average annual insurance premium per family (now at over $10,000), but with far superior coverage.

The second possible funding mechanism is the insurance model, which allows for more flexibility and is insulated from the whims of the legislature and generalized statutory spending limitations. A Colorado Health Care Insurance Plan administered through the CHS will allow government entities to make premium payments just as they do now. Employers will continue to pay their medical portion of workers compensation as mandated by law to the CHS.

The Colorado Department of Revenue income tax withholding system could be used to receive employer/employee health care contributions at the same time they receive income tax withholding. Employers have the option to pay all, some, or none of the employee contribution.

When individuals file their Colorado income tax returns, their CHS premium/contribution will be entered under the designation "Colorado Health Services Contribution," so that consumers are conscious of their own and/or their employer's contributions to the system.

The insurance model permits the CHS more flexibility by making use of actuarial social insurance science to set rates up or down in any given year depending on utilization, reimbursement standards, newly proposed government regulations etc.

Other funding mechanisms are available such as a gasoline tax to cover automobile-related injuries, additional alcohol and cigarette taxes, taxes on weapons and ammunition to cover firearm- related injuries, etc. Any monies derived from these sources could be used to expand services or decrease health care premium contributions.

l)(4) How will distribution of costs for individuals, employees, employers, government, or others be affected by this proposal? Will each experience increased or decreased cost? Please explain.

This proposal will dramatically decrease cost for employers and individuals who are currently paying for private insurance. Because the insurance premium payment for state and local government workers and retirees under the plan will be less than state and local governments now pay for worker and retiree health benefits, the net cost of the program will result in significant savings. The public education system will also benefit from the ability to redirect funding to education. There will be increased cost for those who currently refuse to

purchase health care coverage. For most Coloradans who desire coverage but cannot afford it, the plan makes coverage affordable. Since participation is mandated, everyone pays and everyone is covered.

l)(5) Are there new mandates that put specific requirements on payers in your proposal? Are any existing mandates on payers eliminated under your proposal? Please explain.

Everyone pays into the system and everyone is covered.

l)(6) How will your proposal impact cost-shifting?

Under this plan, cost-shifting is eliminated as everyone is covered and providers are paid equally for their services rendered.

l)(7) Are new public funds required for your proposal?

Since those funds that are currently being driven into the private sector will be redirected as contributions to the CHS, essentially no new funds will be required.

l)(8) If your proposal requires new public funds, what will be the source of those new funds?

Other funding mechanisms are available such as a gasoline tax to cover automobile related injuries, additional alcohol and cigarette taxes, taxes on weapons and ammunition to cover firearm related injuries, etc. Any monies derived from these sources could be used to expand services or decrease health care premium contributions.

Description of the Comprehensiveness of the Health Care for All Colorado Plan

This plan encompasses the definition of major health care reform. Its changes are truly comprehensive. Coverage is comprehensive. Every resident of the State of Colorado has comprehensive coverage under the plan. Benefits are comprehensive. Everyone has the same basic coverage.

Quality and safety issues are comprehensive. With an integrated, statewide health information technology network, outcomes, expenditures, and utilization can be tracked across the entire state and meaningful adjustments made for resources that will enhance the overall well being of the entire population. It will also permit the ability to address the specific needs of regions, groups with special needs, and minorities.

Governance is comprehensive. All regions of the state have representation on the Board of the Colorado Health Services. The administration of the system is required to be transparent and the Board is required to plan open forums so that everyone has the opportunity to provide input into the budgetary process and the allocation of resources.

The changes made in the way that we practice medicine are comprehensive. Because hospitals and providers no longer have to compete to see who can avoid the poorest paying patients, they can actually start competing against one another on issues of quality, outcomes, and patient satisfaction — which is what medicine is supposed to be about.

The positive effects on business are comprehensive. Since all businesses contribute equally, it will level the playing field and promote competition. Since the administrative burden of contracting with several types of insurance is minimized and the overall cost of health care coverage is reduced, business will invariably become more profitable and competitive, thus attracting more business and industry to our state, resulting in improved wages for our middle class and increased state revenues. Also, since portability is not an issue, individuals have the option to return to school to enhance their education or to start their own small business without fear of losing their health coverage.

The positive effects on medicine, business, and Coloradans are truly comprehensive.

How this proposal was developed

A series of Colorado groups have promoted single-payer health care since the early '90s. The statewide Colorado Coalition for Single Payer (CCSP), the Boulder Health Policy Watch, and the Colorado Gray Panthers became Health Care for All Colorado. In 2000, retired public health professor Ron Forthofer and Bob Danknich authored a Colorado study illustrating the savings of a single-payer approach. Dr. Elinor Christiansen, HCAC board president, was one of 17 physicians to draft a national single-payer health care plan in 2000. (The current bill is HR676.) In 2006, statewide HCAC citizen health care hearings helped illuminate the many disparities and barriers to access, rising costs, frustrations and waste in health care in Colorado.

Actively involved since the early '90s in formulating health care solutions, the Colorado Nurses Association (CNA) worked on the Colorado Care Project for universal health care in 1993, and, with the American Nurses Association, worked toward creation of the comprehensive document – *Nursing's Agenda for Health Care Reform.* The CNA statewide health care task force contributed to the development of the Health Care for All Colorado proposal. In 2005 CNA's House of Delegates endorsed single-payer universal health care as the preferred solution to the U.S. health care dilemma.

The primary author, Dr. Rocky White, is a full time practicing primary-care physician in Alamosa, Colorado. In the last few years he has personally seen many of his patients, as well as others in the San Luis Valley, lose their jobs and their homes, have access to adequate care denied, and even die because of issues surrounding poor or no health care coverage. In fact in 2004 Dr. White's multi-specialty group in Alamosa had to close its doors because it could no longer survive financially due to the constraints of our current system.

Since that time he has become convinced that a single payer mechanism of financing is the only way to provide quality, affordable and accessible care to everyone in Colorado, and he has been actively engaged in working with groups across the state for its promotion.

In 2005 the Colorado Medical Society House of Delegates voted 91 percent in favor of comprehensive health care reform.